

## **MEM-CL-Plan of Care (POC) C3**

**Purpose:** The purpose of this workflow is to provide a step-by-step process for the Health Coach (HC) to develop a Plan of Care that appropriately addresses the Member's individualized needs and barriers related to their health status. The steps include adding the appropriate problem, the associated goal the member wants to accomplish, and the intervention by which the nurse will assist the member in reaching their goal. The nurse will also take into consideration those interventions already captured in the Percolator Call List related to the clinical metrics.

### **Identification of Roles:**

- Health Coach (HC) – Development and on-going collaboration on members individualized treatment plan
- Health Coordinator – Assists Health Coach with scheduling of member appointments and assist with community and support services

### **Performance Standards:**

NA

### **Path of Business Procedure:**

#### **Step 1: Adding a Problem**

- a. Select Plan of Care from the left Navigation tree
- b. Click Add Problem
- c. Select a problem from the Problem drop down menu
- d. Choose an appropriate category from the Category drop down menu
- e. Click Save

#### **Step 2: Adding a Goal**

- a. Scroll to the right of the Added Problem
  1. Click the Target
  2. Enter the Target Date = the date of next follow-up assessment
- b. Choose Goal Class
  1. Your choice will determine the type of interventions displayed when adding interventions
  2. Choose from the drop list

- c. Choose a Goal appropriate for the Problem selected
- d. Click Save

### Step 3: Adding an Intervention

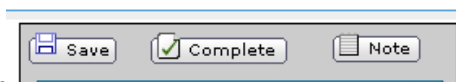
- a. Scroll to the right of the added problem
- b. Click Show - this will expand the problem and goal information
- c. Click the **Blue!** (This is the button to add an Intervention)
- d. Select an Intervention from the Intervention drop down menu
  - 1. The drop down will display a partial sentence until clicked, the entire intervention will display below the drop down
  - 2. TIP: Click an Intervention then use the “down” cursor key to preview the sentence and scroll through the available interventions quickly
  - 3. \*\* Avoid Interventions already addressed on the Percolator Call List \*\*
  - 4. “Other” can be used to make the Intervention selected more specific to the Member’s needs
- e. Click Save
- f. Select Plan of Care from the left navigation tree; click “Preview Care Plan” to view entire care plan
- g. Review the goals with the member
  - 1. Discuss and agree on a follow up date to review the member’s progress relating to the established goals
- h. The activity follow up date should be in accordance to touch level by selecting the frequency in the care plan
  - 1. High= monthly, Medium= only once and adjust dates and Low =semi-annual

### Step 4: Plan of Care

- a. The Plan of Care is generated two different ways. A generic plan of care is generated upon completion of most assessments. The health coach is redirected to that site while completing the assessment, as part of that process

### Step 5: Assessment Generated Plan of Care

Once the health coach selects Complete, they will then be redirected to the Plan of Care screen.

A screenshot of a web application titled 'Assessments'. It features a table with columns for 'Title', 'Frequency', 'Start Date', and 'Target Date'. The table contains several rows of assessment items, each with a checkbox in the first column. The items include 'Knowledge deficit related to physical activity/exercise', 'Educate on importance of physical activity/exercise', 'Review Physical Activity Interventions', 'Knowledge deficit related to the vaccine', 'Educate on importance of the vaccine', 'Review Self Management Interventions', 'Knowledge deficit related to psychosocial vaccine', 'Educate on importance of psychosocial vaccine', 'Review Self Management Interventions', 'Identify for complications related to stress', 'Educate on Stress Management', 'Review Stress Management Interventions', 'Possible Depression', 'Screen for depression', and 'Complete Page'. The 'Frequency' column has a dropdown menu set to 'Monthly'. The 'Start Date' and 'Target Date' columns have date pickers. A legend at the top indicates 'New' (pink), 'In Progress' (red), 'Careplan Creation' (yellow), and 'Completed' (green). A 'DHGeneral' dropdown is also visible.

- a. To modify the care plan, select and deselect by checking the boxes to the left of the Problem Goals and Interventions (PGIs)
  1. If you deselect the problem (brown line), the Goals and Interventions are deselected also. If you deselect the Intervention (grey line), the problem and goal will remain

The screenshot shows the 'Assessments' interface for 'DMGeneral Assessment List'. It displays a table with columns: Title, Frequency, Start Date, and Target Date. The table lists several PGIs and their associated interventions. A blue oval highlights the 'Frequency' column, and arrows point to the checkboxes for each PGI.

Title	Frequency	Start Date	Target Date
<input checked="" type="checkbox"/> Knowledge deficit related to physical activity/exercise			
<input checked="" type="checkbox"/> Educate on importance of physical activity/exercise			
<input checked="" type="checkbox"/> Review Physical Activity Interventions	Monthly		
<input checked="" type="checkbox"/> Knowledge deficit related to flu vaccine			
<input checked="" type="checkbox"/> Educate on importance of flu vaccine			
<input checked="" type="checkbox"/> Review Self Management Interventions	Monthly		
<input checked="" type="checkbox"/> Knowledge deficit related to pneumococcal vaccine			
<input checked="" type="checkbox"/> Educate on importance of pneumococcal vaccine			
<input checked="" type="checkbox"/> Review Self Management Interventions	Monthly		
<input checked="" type="checkbox"/> Potential for complications related to stress			
<input checked="" type="checkbox"/> Educate on Stress Management			
<input checked="" type="checkbox"/> Review Stress Management Interventions	Monthly		
<input checked="" type="checkbox"/> Possible Depression			
<input checked="" type="checkbox"/> Screen for depression			
<input checked="" type="checkbox"/> Complete PHQ9	Monthly		

Complete Careplan

- b. Update the frequency of each Intervention by choosing from the drop down
  1. This generates an Activity as a Follow-Up to remind the health coach when to complete the interventions
  2. By selecting Monthly once the Activity has been completed the computer will auto-generate a new Activity one month from the date of completion of the previous Activity
- c. Update the target and end dates for each PGI that the HC chooses to keep
  1. The target dates and end dates are the same
  2. This is the date the health coach and the member feel the goal may be accomplished
- d. Select the start date, which is the date the health coach will contact the member, and start actively working towards the goal
  1. The health coach can do that by either using the calendar tool or typing in MM/DD/YYYY

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Title	Frequency	Start Date	Target Date
<input checked="" type="checkbox"/> Knowledge deficit related to physical activity/exercise			
<input checked="" type="checkbox"/> Educate on importance of physical activity/exercise			09/22/2009
<input checked="" type="checkbox"/> Review Physical Activity Interventions	Quarterly	09/22/2008	09/22/2009
<input checked="" type="checkbox"/> Knowledge deficit related to flu vaccine			
<input checked="" type="checkbox"/> Educate on importance of flu vaccine			12/22/2008
<input checked="" type="checkbox"/> Review Self Management Interventions	Only Once	10/22/2008	12/22/2008
<input checked="" type="checkbox"/> Knowledge deficit related to pneumococcal vaccine			
<input checked="" type="checkbox"/> Educate on importance of pneumococcal vaccine			
<input checked="" type="checkbox"/> Review Self Management Interventions	Monthly		
<input checked="" type="checkbox"/> Potential for complications related to stress			
<input checked="" type="checkbox"/> Educate on Stress Management			
<input checked="" type="checkbox"/> Review Stress Management Interventions	Monthly		
<input checked="" type="checkbox"/> Possible Depression			
<input checked="" type="checkbox"/> Screen for depression			09/22/2009
<input checked="" type="checkbox"/> Complete PHQ9	Semi-annual	09/22/2008	09/22/2008

Complete Careplan

As you can see, here only 3 have been selected for education. At this point, these three will be added to the Care Plan and more PGIs will be added as each assessment is completed

- e. Select complete care plan from the bottom of the screen to complete the assessment

Assessments

DMGeneral Assessment List

New In Progress Careplan Creation Completed

Title	Frequency	Start Date	Target Date
<input checked="" type="checkbox"/> Knowledge deficit related to physical activity/exercise			
<input checked="" type="checkbox"/> Educate on importance of physical activity/exercise			09/22/2009
<input checked="" type="checkbox"/> Review Physical Activity Interventions	Quarterly	09/22/2008	09/22/2009
<input checked="" type="checkbox"/> Knowledge deficit related to flu vaccine			
<input checked="" type="checkbox"/> Educate on importance of flu vaccine			12/22/2008
<input checked="" type="checkbox"/> Review Self Management Interventions	Only Once	10/22/2008	12/22/2008
<input checked="" type="checkbox"/> Knowledge deficit related to pneumococcal vaccine			
<input checked="" type="checkbox"/> Educate on importance of pneumococcal vaccine			
<input checked="" type="checkbox"/> Review Self Management Interventions	Monthly		
<input checked="" type="checkbox"/> Potential for complications related to stress			
<input checked="" type="checkbox"/> Educate on Stress Management			
<input checked="" type="checkbox"/> Review Stress Management Interventions	Monthly		
<input checked="" type="checkbox"/> Possible Depression			
<input checked="" type="checkbox"/> Screen for depression			09/22/2009
<input checked="" type="checkbox"/> Complete PHQ9	Semi-annual	09/22/2008	09/22/2008

Complete Careplan

- f. This screen will generate, showing the health coach that the assessment has been completed.

Assessments						
DMGeneral Assessment List						
<div> <div></div> New           <div></div> In Progress           <div></div> Careplan Creation           <div></div> Completed         </div> Assessment/Careplan has been completed successfully						
Assessment Date	Type	Status	Clinical Acuity	Clinical Score	Episode Idn	Action
09/23/2008	Initial Assessment	Completed	0	0	530	View Report
<div>Add</div>						

- g. Above, you can see that the assessment has been highlighted in green where, on prior screen shots along the top, the health coach can see it was highlighted in yellow (in the Care Plan Creation stage)

### Step 6: To change or update information on the Plan of Care:

- Select Plan of Care from the left hand navigation tree
  - The Plan of Care tab allows the health coach to adjust start dates, call frequency, and end dates for problems, goals and interventions
  - Within this tab, the health coach may also add problems, goals and interventions

The screenshot shows the 'Plan of Care' interface for patient CATHY MOUSER. The left navigation pane has 'Plan Of Care' selected. The main area displays patient information (Name: CATHY MOUSER, ID: 1005903419591204, Age: 48, DOD: , Phone: (419)339-2316, Sex: F, Language: ), episode details (Episode Type: DM, Race: , PCP Name: , PCP Phone: , Acuity: 0, TRS Score: , ...More), and tabs for Medications (From Claims), Conditions (From Claims), and Procedures (From Claims). Below these tabs are buttons for Add Activity, Allergies: No ...More, Print, Add Issue, and Send Message. At the bottom, there is a section for Plan Of Care with tabs for Episode View and Patient View, and an Add Problem button. A large black arrow points to the 'Plan Of Care' tab in the left navigation pane. Another black arrow points to the 'Add Problem' button at the bottom of the Plan Of Care section.

- Select Patient View in Plan of Care and expand all
  - The care plan will open up so the health coach may adjust the goal to long term
  - The health coach may also adjust dates and call frequency in this area as well
  - Since the health coach will be reassessing the member's disease/condition every 6 months, keep in mind that a long-term goal will be 6 months and a short term goal will be 3 months
  - This could differ depending on the contract, so please check your department specific workflows

Plan Of Care

Episode View Patient View

Filter : Open Goals

Problem	Category	Date Added	
Possible Depression	DM General	09/23/2008	Show
Knowledge deficit related to flu vaccine	DM General	09/23/2008	Show
Knowledge deficit related to physical activity/exercise	DM General	09/23/2008	Show

Expand All

- c. Select the goal ([Blue link](#) along the goal line of the Plan of Care) to review and update each individual goal after you have created the plan of care
1. Here the health coach can update the goal type from long to short term, update the dates if information changes, etc.
  2. The health coach will also need to go to this screen to enter the actual achieved date for the goal, if it was met or not, and the variance if needed

Plan Of Care

Episode View Patient View

Filter : Open Goals

Problem	Category	Date Added	
Possible Depression	DM General	09/23/2008	Hide
<div> <div>09/22/2009</div> <div>Screen for depression</div> </div>	DM General	09/23/2008	Hide
<div> <div>Target Date</div> <div>Goal</div> <div>Goal Type</div> <div>Goal Met</div> <div>Achieved Date</div> </div>			
<div> <div>09/22/2009</div> <div>Screen for depression</div> <div>ShortTerm</div> </div>			
<div> <div>Intervention</div> <div>Status</div> <div>Start Date</div> <div>Target Date</div> <div>Assigned Nurse</div> </div>			
<div> <div>Complete PHQ9</div> <div>Open</div> <div>09/22/2008</div> <div>09/22/2008</div> <div>Meghan Matt</div> </div>			
Knowledge deficit related to flu vaccine	DM General	09/23/2008	Hide
<div> <div>Target Date</div> <div>Goal</div> <div>Goal Type</div> <div>Goal Met</div> <div>Achieved Date</div> </div>			
<div> <div>12/22/2008</div> <div>Educate on importance of flu vaccine</div> <div>ShortTerm</div> </div>			
<div> <div>Intervention</div> <div>Status</div> <div>Start Date</div> <div>Target Date</div> <div>Assigned Nurse</div> </div>			
<div> <div>Review Self Management Interventions</div> <div>Open</div> <div>10/22/2008</div> <div>12/22/2008</div> <div>Meghan Matt</div> </div>			
Knowledge deficit related to physical activity/exercise	DM General	09/23/2008	Hide
<div> <div>Target Date</div> <div>Goal</div> <div>Goal Type</div> <div>Goal Met</div> <div>Achieved Date</div> </div>			
<div> <div>12/22/2008</div> <div>Educate on importance of physical activity/exercise</div> <div>ShortTerm</div> </div>			
<div> <div>Intervention</div> <div>Status</div> <div>Start Date</div> <div>Target Date</div> <div>Assigned Nurse</div> </div>			
<div> <div>Review Physical Activity Interventions</div> <div>Open</div> <div>09/22/2008</div> <div>09/22/2009</div> <div>Meghan Matt</div> </div>			

Collapse All

- d. Once the information has been changed, select save

**Edit Goal**

Target Date for achieving the goal: 09/22/2009

Goal Class: Education

Goal Type: Short Term

Goal: Educate on importance of physical activity/exercise

Other:

Details:

Actual Achieved Date:

Goal Met: ☐ Yes ☐ No ☐ Partial

Reason Not Met: --Select one--

Cancel Save

### Step 7: Episode View of the Care Plan

Another way the Care Plan can be viewed, is found in the Episode View of the Plan of Care

- a. Select Episode View

**Plan Of Care**

Episode View Patient View

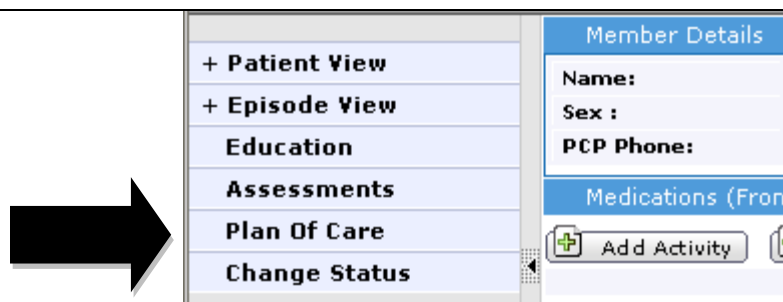
Problem	Category	Date Added	Actions
Possible Depression	DM General	09/23/2008	Show
Knowledge deficit related to flu vaccine	DM General	09/23/2008	Show
Knowledge deficit related to physical activity/exercise	DM General	09/23/2008	Show

Add Problem Preview CarePlan

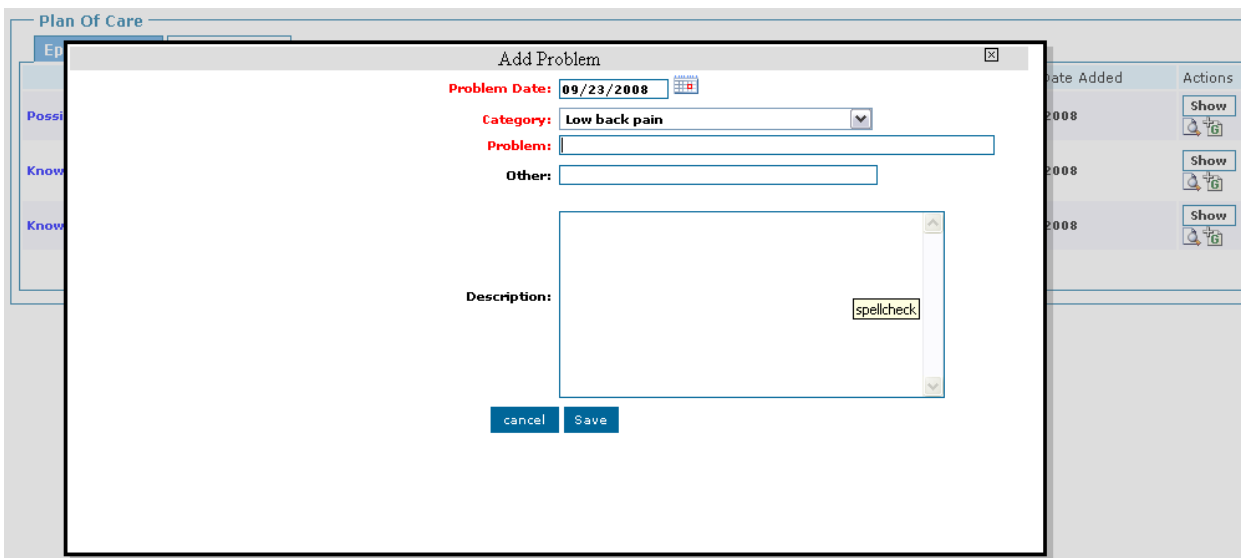
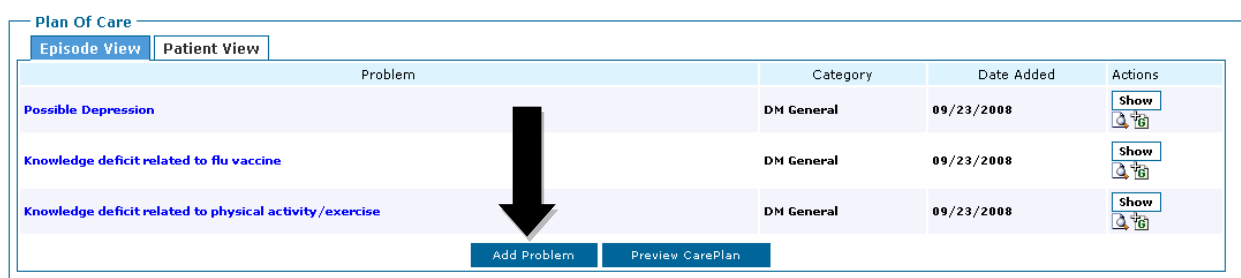
- b. Select Preview Care Plan located at the bottom of the screen
  1. Within this screen, it is possible for the health coach to view the last interaction dates and notes for each interaction
  2. In the upper right hand corner is a "print" button, so the health coach could print out the care plan for review or send to the member







- b. To add a problem select Add Problem as seen in the picture below.  
1. After selecting, the Add Problem screen will appear




- c. The health coach must select a category from the list of options; create a problem, then select save  
1. The problem date automatically defaults to the date that the health coach is adding the problem
- d. To add a Goal, select the +G from the right side of the screen, located under the show button

Plan Of Care			
Episode View Patient View			
Problem	Category	Date Added	Actions
Patient does not have an asthma action plan	WY Quality Variable	10/27/2008	Show
Member's BMI is greater than 25	WY Quality Variable	10/27/2008	Show Add Goals
Member did score positively on the depression questions	WY Quality Variable	10/27/2008	Show
Possible Depression	DM General	10/27/2008	Show
Potential for complications related to stress	DM General	10/27/2008	Show
Knowledge deficit related to nutrition	DM General	10/27/2008	Show
Potential for complications due to asthma triggers	Asthma	10/27/2008	Show
Add Problem		Preview CarePlan	





- e. Once selected, enter the Target Date, Goal Class, and Goal Type.
  1. Will default to short term, update if it is a long-term goal.
- f. Search and find the desired Goal.
  1. To complete the search, only type in the first three characters from the goal.
  2. For example, search using "ast" for Asthma.

Plan Of Care		Add Goal	
Target Date for achieving the goal:	01/31/2009	Goal Class:	*** ALL **
Goal :	Short Term	Goal Type:	Short Term
(For a quick search please enter 3 chars from Goal)			
Other:	<div> <div>ast</div> <div>Please Select One</div> <div>           Educate on fasting blood sugar checks            Educate on worsening Asthma symptoms            Educate on importance of asthma action plan            Increase knowledge rA breast feeding         </div> </div>		
Details:			

- g. Select the goal from the provided options and select save
- h. To see the goal listed, select show on the right hand side of the screen, located below the problem where the goal was added
  1. In the screen that populates, the goal will be listed

Problem	Category	Date Added	Actions
Patient does not have an asthma action plan	WY Quality Variable	10/27/2008	Show 












Problem	Category	Date Added	Actions			
Patient does not have an asthma action plan	WY Quality Variable	10/27/2008	<div>Hide</div> <div></div>			
Data has been saved successfully 						
Target Date	Goal	Goal Type	Goal Met	Achieved Date	Episode Id	Actions
07/14/2008	Member to obtain/use action plan	Short Term	N		1038	
Intervention	Status	Start Date	Target Date	Assigned Nurse	Episode Id	Actions
HC to educate and help member in completing an asthma action plan	Closed	03/16/2009	07/14/2008	Meghan Matt	1038	
01/31/2009	<a href="#">Educate on importance of asthma action plan</a>	Short Term			1038	<div></div> <div></div>



## Step 9: Adding an Intervention

- Select the +i icon all the way to the right on the line with the goal

Problem	Category	Date Added	Actions			
Patient does not have an asthma action plan	WY Quality Variable	10/27/2008	<div>Hide</div> <div></div>			
Data has been saved successfully 						
Target Date	Goal	Goal Type	Goal Met	Achieved Date	Episode Id	Actions
07/14/2008	Member to obtain/use action plan	Short Term	N		1038	
Intervention	Status	Start Date	Target Date	Assigned Nurse	Episode Id	Actions
HC to educate and help member in completing an asthma action plan	Closed	03/16/2009	07/14/2008	Meghan Matt	1038	
01/31/2009	<a href="#">Educate on importance of asthma action plan</a>	Short Term			1038	<div></div>



- Enter a Start Date, target date and select an Intervention.
  - Assign Nurse will update to the current user if not assigned.
  - Frequency: update to what you want the frequency to be
  - Type in the first 3 characters of the topic you would like for the Intervention (as done previously with the "ast" for asthma example)

Plan Of Care

Add Intervention

Intervention/Start Date: 01/05/2009 11:00 AM 11:00 AM

Target Date: 12/31/2009

Assign Nurse: --Select One--

Frequency: Only Once

Intervention:  
(For a quick search please enter 3 chars from Intervention)

ast

Please Select One

- Educate member on breast feeding
- HC to educate and help member in completing an asthma action plan
- HC to educate and help member in signs and symptoms of asthma
- Review asthma action plan in Self Management
- Review fasting blood sugar in Self Management

Other:

low knowledge deficit related to nutrition

DM General

10/27/2

- c. Select save and the PGI has been individually added for the member

Add Intervention

Intervention/Start Date: 01/05/2009 11:00 AM 11:00 AM

Target Date: 12/31/2009

Assign Nurse: --Select One--

Frequency: Only Once

Intervention:  
(For a quick search please enter 3 chars from Intervention)

HC to educate and help member in completing an asthma action plan

HC to educate and help member in completing an asthma action plan

Other:

Cancel Save

### Step 10: Complete a Care Plan Activity/Interaction.

- Select the activity on the Activities screen in Episode View from the navigation tree (as opposed to within the Plan of Care)
  - For example: Complete PHQ9.

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Member Services

**Activities/Interventions**

**Open Activities/Interventions**

Select	Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Frequency
<input type="checkbox"/>	Admission	<a href="#">Review Physical Activity Interventions</a>	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Quarterly
<input type="checkbox"/>	Admission	<a href="#">Complete PHQ9</a>	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Semi-annual
<input type="checkbox"/>	Admission	<a href="#">Review Self Management Interventions</a>	10/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	

[Add New](#) [Modify](#) [Close](#) [Close All](#)

**Closed Activities/Interventions**

There are no Closed Activities/Interventions.

- b. The health coach will fill in the interaction screen with a brief note,
  1. For example: "completed the PHQ9, member scored 10, will follow up as planned"
- c. Select save.

**Interactions**

[View History](#)

**Interactions Add**

Date: 09/23/2008

Problem: Possible Depression

Goal: Screen for depression

Encounter Type: Admission

Intervention: Complete PHQ9

Entity: Member

Mode: Telephone

Link to Tool: Assessment  
Primary Care  
Specialty Care  
Lab  
Diagnostic Tests / Screens

Outcome: Spoke with Member

Outcome Type: Successful

Follow-Up required: ☐ Yes ☒ No

Notes: \*mbr (ssh) completed PHQ9 assessment, member scored 10. Will continue to f/u with member as planned.

[Save](#)

- d. The intervention/activity that was just completed will be seen under closed activities/interventions

**Activities/Interventions**

**Open Activities/Interventions**

Select	Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Frequency
<input type="checkbox"/>	Admission	<a href="#">Review Physical Activity Interventions</a>	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Quarterly
<input type="checkbox"/>	Admission	<a href="#">Review Self Management Interventions</a>	10/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	
<input type="checkbox"/>	Admission	<a href="#">Complete PHQ9</a>	03/23/2009 12:00 AM		Meghan Matt	Meghan Matt	Semi-annual

Add New
Modify
Close
Close All

**Closed Activities/Interventions**

Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Activity Added
Admission	Complete PHQ9	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	09/23/2008

- e. The health coach can go back to the plan of care and see this entry under Preview Care Plan as well.

Care Plan Preview											Print
Problem	Goals	Interventions	Status	Met	Start Date	Target Date	End Date	CM Assigned	F/U Frequency	Last Interaction Date	Notes
Possible Depression	Screen for depression	Complete PHQ9	Open		09/23/2008	09/22/2009		Meghan Matt	Semi-annual	09/23/2008	*mbr (ssh) completed PHQ9 assessment, member scored 10. Will continue to f/u with member as planned.
					09/22/2008	09/22/2008					
Knowledge deficit related to flu vaccine	Educate on importance of flu vaccine	Review Self Management Interventions	Open		09/23/2008	12/22/2008		Meghan Matt	Only Once		
					10/22/2008	12/22/2008					
Knowledge deficit related to physical activity/exercise	Educate on importance of physical activity/exercise	Review Physical Activity Interventions	Open		09/23/2008	09/22/2009		Meghan Matt	Quarterly		
					09/22/2008	09/22/2009					

## Forms/Reports:

Refer to the following operations documents:

Disease Management Assessment Process

My Action Plan- Disease Specific

Clinical Guidelines-Disease Specific

Glossary of Acronyms

## RFP References:

RFP MED-6.5.7 Page 197

## Interfaces:

C3

Data Warehouse

MEM-CL-MEM - CL - PLAN OF CARE (POC)Plan of Care (POC) C3 Rev. (2/16/15)

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**Attachments:**

None